

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2009
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NAME OF PROVIDER OR SUPPLIER N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599
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F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during the annual RECERTIFICATION SURVEY.</p> <p>Representing the Department of Public Health:</p> <p>Adrian Long HFEN, Ann Fitzgerald HFEN, George Ely HFEN, Paula Reichmuth HFEN, Carol Devita HFEN, Candice Bergseth HFEN and Bernadette Brown HFEN.</p> <p>The census on entry to the facility was 351 residents.</p> <p>The survey sample included 30 sampled residents and 2 non-sampled residents.</p>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code, Section 1250, and Title 42, Code of Federal Regulations (CFR) 405.1907. This plan of correction constitutes our written credible allegation of compliance for the deficiencies noted.</p> <p>(<i>[Signature]</i>) Initials</p>	
F 156 SS=E	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for</p>	F 156	<p>F 156 Plan of Correction: The facility will ensure the correct address of the State survey/certification and licensure office, is updated and posted where it's easily visible on all resident occupied units.</p> <p>The Quality Assurance office updated the notice of rights and services, Patient Advocacy Information, on March 3, 2009. The form was enlarged and printed on legal size paper. The information was posted in all occupied licensed care wards on bulletin boards near or at the nursing stations at a level where residents who are wheelchair bound could read the information.</p> <p>Standards Compliance will coordinate with Nursing Services to establish a standard for posting patient related information in occupied licensed care areas.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>[Signature]</i>	Standards Compliance Coordinator	4/28/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable; 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

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F 156	<p>Continued From Page 1</p> <p>which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident</p>	F 156	<p>Continued from page 1:</p> <p>Finding 1. An updated Patient Advocacy Information notice was posted in the Eisenhower Unit at a level where residents who are wheelchair bound could read the information.</p> <p>Finding 2. An updated Patient Advocacy Information notice was posted on Unit 2B at a level where residents who are wheelchair bound could read the information.</p> <p>Finding 3. An updated Patient Advocacy Information notice was posted on Ward 7 at a level where residents who are wheelchair bound could read the information. Licensed staff will be notified of the updates and the need to remain posted at an appropriate level.</p> <p>Finding 4. An updated Patient Advocacy Information notice was posted on Units 1B and 1C at a level where residents who are wheelchair bound could read the information. Ward 1D was recently closed and the beds put into suspense. Responsible: Standards Compliance Coordinator Monitor: Nursing Service and Standards Compliance will monitor standardized postings in designated areas quarterly.</p>		4/04/09

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F 156	<p>Continued From Page 2</p> <p>may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This Requirement is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to consistently post the correct address of the State survey and certification, and licensure office, easily visible, on all resident units. The facility failure to do so created the potential for resident's inability to file a complaint with the State agency.</p>	F 156		

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F 156	Continued From Page 3 Findings: 1. During the initial tour of the Eisenhower Unit on 3/2/09 at 10 a.m., observation of required posting revealed that the posting was not prominently displayed at a level where those residents who are wheelchair bound, would be able to read the information. 2. During the dining observation on Unit 2B on 3/2/09 at 12:30 p.m., observation of the required posting revealed the incorrect address of the local State survey, certification, and licensure office. 3. On 3/4/09 at 10:30 a.m., observation of the Ward 7 required posting revealed that the address was incorrect as to the state agency residents were to contact when they wish to make a complaint about the facility. During an interview on 3/4/09 at 11 a.m., licensed Staff F was unaware that address posted for the state agency was incorrect. 4. On 3/4/09 at 3:00 p.m., during a tour of residences 1B, 1C and 1D with licensed Staff J, observation revealed that the required posting was not prominently displayed at a level where those residents who are wheelchair bound, would be able to read the information.	F 156		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by:	F 241	F 241 Plan of Correction: The facility will ensure that residents are treated with dignity and respect.	

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F 241	Continued From Page 4 Based on random observation and staff interview, the facility failed to ensure that one non-sampled resident was treated with dignity and respect (Resident 31). The facility failure to promote care for a resident in a manner that maintains his individuality, created the potential for Resident 31's loss of self-worth. Findings: On 3/2/09 at 9 a.m., during a tour of residence 2D with licensed staff D, licensed Staff A and Resident 31 were observed in the hallway directly in front of the nursing station. Licensed Staff A stated loudly to Resident 31, "Go lay on your bed. She'll be there in minutes." During an interview with licensed Staff A on 3/2/09 at 10 a.m., Staff A stated the resident was difficult and responded only to short simple commands. Following the observation of the verbal interaction, licensed staff D verbally acknowledged licensed Staff A's negative interchange with Resident 31 and stated the situation would be handled. A review of Resident 31's care plans revealed an update on 3/2/09 to give brief, simple, concrete specific explanations when instructing the resident.	F 241	Continued from page 4: Staff Member A was removed from resident contact during the investigation after the observation by the surveyor was reported. Staff Member A received verbal and written counseling regarding her disrespectful interaction with Resident 31. She also received a confidential action related to progressive discipline. Resident 31's care plan was updated on 3/2/09 to clarify how best to communicate with him. The SRN met with Resident 31 to ensure he was not harmed by the incident. Staff Member A is being closely monitored by the SRN. The SNII will receive weekly reports from the SRN. Five Residents on 2D will be interviewed by the SRN weekly for one month about how they feel about their treatment by staff. Residents will be interviewed periodically after that month. If any problems are identified through observations or interviews of staff and residents, Staff Member A will be removed from resident contact and adverse action will be requested. House-wide in-service will be provided to staff on all three shifts discussing that any interaction with residents that are disrespectful or undignified in anyway will not be tolerated. Staff will be required to review and sign the Professional Conduct/Treatment of Resident's Policy. Responsible: Supervising Nurse II Monitor: Any negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.	
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This Requirement is not met as evidenced by:	F 246	F 246 Plan of Correction: The facility will ensure residents individual needs are met in a timely manner.	04/23/09

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F 246	Continued From Page 5 Based on random observation and resident interview, the facility failed to accommodate one non-sampled resident (Resident 31), with his indwelling urinary catheter drainage bag in a timely manner, so that the resident could attend a planned activity. Findings: Observations of Resident 31 on 3/2/09 at 9 a.m., and 3/3/09 at 8:30 a.m., revealed him sitting on an electric scooter with his indwelling urinary catheter drainage bag laying on the flat foot rest area. During interview on 3/3/09 at 8:30 a.m., Resident 31 stated that he attends "calisthenics" every morning and would not be allowed to enter the gym until the drainage bag was "tied up on a leg bag." He further said that he had problems with staff assisting him with his indwelling urinary catheter drainage bag "everyday without exception."	F 246	Continued from page 5: Resident 31 was moved to Unit 1C at his request. Resident 31's care plan was updated and reflects the resident's request for a leg bag including the times when it is to be used. An addition was made to Resident 31's ADL sheet that requires the resident to wear his leg bag when he leaves the unit for activities in the a.m. and it is to be removed at HS and connected to a catheter bag. The ADL record will document that the leg bag is changed per his care plan. Each SRN will review each resident on their units who use Foley catheters to ensure that their catheter bags are covered or hidden when they are up and about including when they leave the unit. The SRN on 1C will notify the staff on all three shifts of the requirements for Resident 31's leg bag. The unit SRN will monitor that the resident is receiving his leg bag in the morning before he leaves the unit. Responsible: Supervising Registered Nurse Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment was provided on Units 1B and 1D. Resident care equipment was not consistently labeled and properly stored to prevent cross contamination, dirty laundry was observed on the floor of one room, and the floors of two rooms were noted to be dirty and appeared unsanitary. Findings:	F 253	F 253 Plan of Correction: The facility will ensure a sanitary environment is provided to residents.	04/23/09

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F 253	<p>Continued From Page 6</p> <p>During the initial tour of Units 1B and 1D on 3/2/09 at 10 a.m., observations revealed the following:</p> <ol style="list-style-type: none"> 1. Previously used towels were observed on the floor of the room on Unit 1B, Room 1, and an unlabeled bedpan was observed in the shared bathroom of that room. 2. An unlabeled urinal was observed on the bed rail of Unit 1B, Room 00 bed A. 3. An unlabeled electric hair trimmer was observed in the bathroom of Unit 1D, Room 4. 4. The floor of Unit 1D, Room 3 was noted to be dirty throughout the entire room. 5. The floor of Unit 1D, Room 6, was observed to have deep yellowish stains throughout the room, and was noted to create a tacky sound as the soles of the shoes of the surveyor and nurse walked into the room. Also, the curtains of that room were not attached to the curtain rod. 6. Three unlabeled used toothbrushes were observed in a cup sitting on the shelf above of the sink on Unit 1D, Room 18. This room is shared by two residents. <p>Licensed Staff J was present during the tour and simultaneously witnessed the observations. During concurrent interview, Staff J was unable to identify which residents the unlabeled personal care items belonged to, and agreed that Rooms 3 and 6, on Unit 1D, were unkempt and required housekeeping and/or maintenance services. Staff J also stated that requests had been made to have the falling curtains repaired in Room 6.</p>	F 253	<p>Continued from page 6:</p> <p>Finding 1. On 1B, towels were removed from the floor. The unlabeled bedpan was disposed of. A new bed pan was labeled and provided to the resident.</p> <p>Findings 2, 3 and 6. On 1B and 1C, the unlabeled urinal and toothbrushes were disposed of. New items were issued and labeled. The electric hair trimmer was labeled.</p> <p>Finding 4. The floor in Room 3 on Unit 1D was machine scrubbed on the afternoon of 3/2/09 (during survey) to immediately correct the soiled floor.</p> <p>Finding 5. The floor in Room 6 on Unit 1D was machine scrubbed on the afternoon of 3/2/09 (during survey) to immediately correct the soiled floor.</p> <p>Unit 1D is now closed. All curtains and cubicles were taken down to laundry. Sanitation is in the process of stripping and re-finishing the entire ward. Sanitation conducts monthly inspections of all areas. Floors that are in need of strip/wax are identified on inspection reports. Because these residents were scheduled to move, Sanitation chose to wait to avoid further disruption.</p> <p>All resident's personal items on 1B and 1D were checked to ensure they were labeled properly. SRNs are to observe during their monthly rounds that the resident's personal care products are labeled with the residents name to ensure corrections are made immediately. The rounds will be documented on the Quality of Care/Quality of Life Rounds Sheet which includes review of personal care items.</p>	

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F 258	Continued From Page 7	F 258	<p>Continued from page 7: House-wide training for all 3 shifts will be provided through nursing education to the nursing staff on the importance of labeling the resident's personal care products to decrease the possibility of spreading a potentially infectious microorganism. The training will include that nurses and aides will observe personal items when doing their rounds to ensure they are labeled with the resident's name and that towels are not to be put on the floors. If floors are dirty, they are to report the observation to the SRNs who will notify Sanitation. If curtains are not attached properly to the rods, the SRN will report this to Plant Operations to be repaired. Responsible: Supervising Registered Nurse Monitor: The SRNs will report the findings of the Quality of Care/Quality of Life Rounds form to the Long Term Care Quality Improvement Committee on a monthly basis. The SRNs will discuss concerns they are finding and will use the committee to seek solutions in helping the facility to ensure a "sanitary environment" is provided for our residents. These concerns and solutions will be monitored through the QA Nursing Office.</p> <p>F 258 Plan of Correction: The facility will ensure that staff and residents are notified when scheduled maintenance may affect comfortable sound levels on the units.</p> <p>Finding 1. Plant Operations staff will inform ward staff if they are going to make noise that may disturb the patients.</p>	04/23/09
F 258 SS=D	<p>483.15(h)(7) ENVIRONMENT- SOUND LEVELS</p> <p>The facility must provide for the maintenance of comfortable sound levels.</p> <p>This Requirement is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure the maintenance of comfortable sound levels when residents were subjected to maintenance work beneath Ward 7 and a noisy nursing station (1 North). The facility failure to notify residents of the scheduled maintenance and noise at the nursing station, created the potential for confusion and distraction in their normal regime.</p> <p>Findings:</p> <p>1. On 3/3/09 at 10:45 a.m. an extremely loud noise that sounded like a jack hammer in the hallway on Ward 7. Staff and residents were surprised and had no idea of the source of the noise. None of the staff or residents had been informed of an impending disruption. During an interview one staff stated it had happened the week before as well.</p> <p>The licensed staff later found out that the source of the noise was a project below Ward 7 in which the plant operations department used a Roto-hammer while installing brackets on the ceiling below.</p> <p>During an interview on 3/4/09 at 9:45 a.m. licensed staff F stated that plant operations usually does inform staff prior to potentially noisy/disruptive work. However there was no prior notification of this disruption that was found.</p>	F 258		

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F 258	Continued From Page 8	F 258	Continued from page 8:	
F 278 SS=D	<p>2. During a confidential resident interview on 3/04/09 at 3:15 p.m., a resident on 1 North stated that the nursing station area is very noisy and that staff can be heard talking loudly among themselves during the night shift.</p> <p>483.20(g) - (j) RESIDENT ASSESSMENT</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This Requirement is not met as evidenced by:</p>	F 278	<p>Finding 2. The NOC shift Supervising Registered Nurse met with the night shift staff on 1North to discuss noise levels on the unit. Staff was reminded to be respectful of residents who are sleeping and to keep their voices down. The I North SRN will interview random residents on 1 North to determine whether there is any continuing problem with noise on NOC shift.</p> <p>The SNIs will make unannounced visits periodically on night shift on all licensed units. If any problems are observed, the SNIs will provide immediate feedback to the staff members involved.</p> <p>The NOC shift SRNs have been instructed to increase their unannounced nightly visits during different times of the evening to ensure that the staff is keeping their voices down.</p> <p>Responsible: Supervising Registered Nurse/SNIs</p> <p>Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p> <p>F 278 Plan of Correction: The facility will ensure that resident assessments are accurate.</p> <p>An annual assessment was completed on 3/16/09 for Resident #12. An assessment of the resident's memory status reflects no memory problem. The resident's care plan has been revised to reflect this.</p> <p>A neuro psych evaluation has been ordered by the physician to assess the resident's ability to drive a motor vehicle.</p>	04/23/09

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NAME OF PROVIDER OR SUPPLIER N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599		
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F 278	<p>Continued From Page 9</p> <p>Based on observation, staff interview, and record review, the facility failed to ensure that resident assessments were accurate in 1 of 30 sampled residents (Resident 12), when the Minimum Data Set (MDS) assessment for short term memory loss was coded incorrectly.</p> <p>Findings:</p> <p>During an interview on 3/3/09 at 9 a.m., Resident 12 indicated that she was not able to be discharged to independent living due to her short term memory deficit. The resident's plan of care indicated a problem of short term memory loss, impaired memory, poor safety awareness and poor judgement. The resident's most recent MDS dated 12/21/08, indicated no memory problem.</p> <p>During an interview on 3/3/09 at 9:30 a.m., licensed Staff H stated that the resident was currently not on the unit, and that she may have driven to the bank. The staff stated that the resident is very independent and even drove herself to a destination approximately 80 miles away, a few months ago.</p> <p>Review of Resident 12's plan of care, reflected no assessment of her driving ability.</p>		F 278	<p>Continued from page 9: Resident 12's assessments will be reviewed for accuracy. A Correction Request Form will be submitted for any inaccuracies identified.</p> <p>For any resident residing in certified areas that drive a motor vehicle, this issue will be assessed and reviewed quarterly during the IDT. If any concerns are identified, appropriate evaluations will be requested. A Denial of Rights will be given to the resident, if it is determined that he/she is not safe to drive.</p> <p>Resident assessments will be reviewed at least quarterly during the Interdisciplinary Team Conference for accuracy. These assessments will be conducted and completed in accordance with the Resident Assessment Instrument guidelines. The SRNs will be in-serviced by the SNIs of the requirement that any resident who drives motor vehicles will have this issue reviewed during the IDT process. Responsible: Supervising Registered Nurse Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p>	04/23/09
F 279 SS=D	<p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's</p>		F 279	<p>F 279 Plan of Correction: A comprehensive plan of care with measurable objectives will be developed to meet a resident's medical, nursing, mental and psychosocial needs.</p>	

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F 279	<p>Continued From Page 10</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This Requirement is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure a plan of care with measurable objectives for 4 of 30 sampled residents (Residents 12, 19, 15, 9, 14 and 16) and 1 non-sampled resident (Resident 31).</p> <p>For Resident 12, there was no plan of care that addressed self-administration of medications to meet the resident's desired discharge goal.</p> <p>For Resident 19, the facility failed to revise a plan of care that included a recommendation for side rails.</p> <p>For Resident 15, the facility failed to ensure a coordinated care plan was developed for a patient receiving Hospice care.</p> <p>For Residents 9, 14, 16, and 31, the facility failed to ensure the plan of care indicated information to assure his hydration needs were met.</p> <p>The facility failures to do so, created the potential for self administration of medication errors, a potential for falls, unmet care needs for a</p>	F 279	<p>Continued from page 10: Finding 1. On 3/17/09, an IDT was held with Resident #12. This was followed by a discussion with the resident and the Supervising Registered Nurse on 3/23/09. On both days, the resident made the decision she did not want to return to residential care. Based on this information, Resident #12 will continue to receive medications from the nurse on the ICF unit as ordered by the physician. A medication trial is no longer appropriate for this resident. Residents who choose to self administer their medications will be evaluated by the IDT. If the IDT determines the resident is competent, the facility policy entitled, Medication, Self-Administration Trial will be implemented. This policy includes updating the resident's care plan to reflect the resident's self administration of medication. The SRNs in ICF will ensure that for any residents who request to go to a lower level of care, the resident will have a medication trial. If the resident fails the medication trial and the IDT believes that the resident has the ability to take his or her medications correctly with some training or modification of their drug regimen, an individual training program will be developed and care planned to attempt to assist the resident to move to a lower level of care.</p>	

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F 279	<p>Continued From Page 11</p> <p>terminal patient, and risk for fluid and electrolyte imbalances.</p> <p>Findings:</p> <p>1. On 3/3/09 at 10:30 a.m., during an interview, Resident 12 stated that she wanted to leave the skilled nursing unit and return to independent living. The resident stated that she had been told she could not live independently because of her inability to take her medications. According to licensed Staff H, the resident is independent in all activities of daily living. The record indicated the resident had some short term memory deficit. The most recent Minimum Data Set assessment tool, dated 12/21/08 indicated no short term memory deficit.</p> <p>During an interview on 3/4/09 at 4:00 p.m., licensed Staff F stated that there should be a self administration of medication assessment, however, none was located in the record. The social worker stated that she was not aware that Resident 12 wanted to move to the residential section. The social worker referred to the last annual meeting dated 7/30/08, during which the resident stated that she was aware of the medication criterion in the residential section and assumed that she was "stuck here" because she had a hard time remembering the specific names or recognizing them from a card on a test situation. She added that she could color code them on her own to know what to take.</p> <p>The resident's plan of care indicated a problem of short term memory loss, impaired memory, poor safety awareness and poor judgement. The only interventions listed were supportive.</p> <p>The record indicated that Resident 12 has 27 medications ordered. There was no evidence in</p>	F 279	<p>Continued from page 11:</p> <p>Finding 2. The care plan was revised on 3/5/09 to include the recommendation that Resident 19 will have his side rails raised when in bed. Staff will be in-serviced on Wards 5 and 6 to ensure the recommendation is followed in accordance with professional standards. Teaching will be provided to Resident 19 about the need for side rails when he is in bed to prevent falls. These side rails will only be the ones at the top of the bed so that the resident can freely get in and out of bed.</p> <p>Finding 3. Resident 15's care plans were reviewed and updated to include a problem pertaining to hospice needs e.g. "Hopelessness" related to terminal illness related to right lung mass. The care plan coordinates the Hospices' care plan with Resident 15's care plan and includes the services Hospice provides on what days and by whom.</p> <p>Finding 4. Resident 9's urinary output has been adequate over a several months period. His goal for his urine output has been discontinued. He now has a goal that his catheter will remain patent without complications.</p> <p>Finding 5. The care plans have been updated to include estimated fluid needs and estimated urinary output for Residents 14, 16 and 31.</p> <p>The SRN will review the medical records of all residents who receive Hospice services and will ensure that the residents care plans reflect coordination of services between the unit and Hospice care.</p>		

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F 279	<p>Continued From Page 12</p> <p>the record that an individualized plan had been developed to incrementally assist Resident 12 to be able to take her medications independently in order to meet this criterion for discharge to an independent residential living unit.</p> <p>2. On 3/4/09, record review indicated that Resident 19 had a history of a fall out of bed on 7/10/08. On 7/15/08 the interdisciplinary team (IDT) recommended, per IDT conference notes, that the resident's bed side rails be raised while the resident was in bed. When interviewed on 3/4/09 facility staff acknowledged that the resident's care plan did not reflect the IDT recommendation. The resident's care plan was not revised to reflect this IDT recommendation until 3/5/09.</p> <p>3. Observation and interview with Resident 15 on 3/3/09 at 11 a.m., and 3/4/09 at 2 p.m. revealed he was receiving the Hospice benefit and was satisfied with the services being provided to him.</p> <p>Record review on 3/4/09 at 2:30 p.m., revealed there was no coordinated plan of care between the facility and Hospice that identified the care and services each would provide.</p> <p>Interview with the Hospice nurse on 3/4/09 at 3:00 p.m., revealed she attends Resident 15's IDT meetings and documents her own care plans, but does not have an integrated plan of care with the facility.</p> <p>Review of the agreement between the facility and Hospice service on 3/4/09 at 3:30 p.m. indicated that " the contractor shall coordinate with the (facility)to develop a plan of care ... a Plan of care shall include all orders, treatments and services to be provided to the patient and family by the contractor." This was</p>	F 279	<p>Continued from page 12:</p> <p>The SRNs will review all resident's who have Foley catheters. For any of these residents who required intake and output monitoring, their care plans will be reviewed to ensure that they include specific fluid requirements in their care plan. The SRNs will complete random chart checks and also at the time of the resident's IDT to ensure that their care plans are being followed and are complete.</p> <p>The policy/procedure "Intake/Output/Fluid Balance" will be revised to include that care plans for residents on intake/output, must specify what the fluid requirements are for each resident.</p> <p>Facility-wide in-service education for nurses will be provided by Nursing Education regarding, residents requesting a lower level of care, ensuring that recommendations made by the IDT are followed-up on such as side rails, the coordination of hospice care service in skilled units, specific fluid requirements for resident on intake/output and the revisions to the I&O policy. Components of a good care plan will be discussed.</p> <p>Responsible: Supervising Registered Nurse</p> <p>Monitor: A monitoring tool for all residents on I & Os will be developed through the QA process. SRNs will complete the tool monthly and report the results through the Long Term Care Quality Improvement Committee when it meets monthly. Any pattern of negative findings related to care planning will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p>		04/23/09

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F 279	<p>Continued From Page 13</p> <p>not reflected in the plans of care reviewed.</p> <p>4. On 3/4/09 at 10 a.m., Resident 9 was observed with an indwelling urinary catheter in place. Record review on 3/4/09 indicated the resident had a history of acute renal failure, pressure sores, congestive heart failure and chronic obstructive pulmonary disease. The resident's medications included a diuretic (Lasix). Resident 9's care plan, problem number 4, included a goal of "adequate (urinary) output." The care plan contained no measurable objective or other information describing what constituted adequate urinary output. The resident's record review revealed that urinary output was not being recorded for Resident 9. During interview on 3/4/09 at 10:30 a.m., licensed Staff G stated that Resident 9 was aware, and could report to staff when his output was not adequate.</p> <p>5. Observations starting on 3/2/09 revealed Residents 14, 16 and 31 had indwelling urinary catheters. In each residents room was an Intake and Output (I & O) collection sheet. Record reviews starting on 3/3/09 revealed the care plans contained no measurable objective or other information describing what constituted adequate urinary output for each individual resident.</p> <p>Review of the facility policies for "Urinary Catheter," "Intake /Output/Fluid Balance " and "Hydration" discuss monitoring I & O, and providing sufficient fluid intake , but fail to instruct staff to review the specific fluid requirements and include it on the care plans.</p> <p>Interview with Staff D on 3/3/09 at 3 p.m. revealed the facility had addressed a concern with I & O through their own quality assurance</p>	F 279			

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F 279	Continued From Page 14	F 279	Continued from page 14:	
	program and was working on a revision of current practices.			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on observations, record review, staff interview, and document review, the facility failed to ensure policies and procedures and physician's orders were implemented to prevent possible complications and to ensure maximal efficacy of medication management for 1 non-sampled resident (Resident 32). The facility also failed to follow a physician's order and implement their policy and procedure for a resident with a dressing change (Resident 14). Findings: 1. On 3/3/09 at 9:17 a.m., the medication nurse was observed administering oral medications to Resident 32. The medication nurse gave the resident one tablet of Metoprolol Tartrate 25mg, a blood pressure medication. Review of the physician's medication recap report for Resident 32 revealed an order for Metoprolol Tartrate 25 mg tab to be given at 9:00 a.m. and 6:00 p.m. and to hold the medication if the resident's weekly systolic blood pressure was less than 100. During an interview with the medication nurse on 03/03/09 at 11:45 a.m., the medication nurse confirmed she did not specifically know what the resident's weekly systolic blood pressure reading was prior to administering the Metoprolol Tartrate	F 281	F 281 Plan of Correction: The facility will ensure policies and procedures and physician's orders are implemented. Finding 1. The nurse who was observed on the Medication Pass on 1C received in- service on the facility's policy/procedure "Medication Administration Standards" and "Medication Administration Times." There was no adverse effect to the resident. For Resident 32, his Medication Administration Record was revised and now includes daily monitoring of blood pressure prior to giving Metoprolol Tartrate. The physician re-evaluated the resident's medication and decreased the dosage of Omeprazole and Prochlorperazine from twice a day to once a day, a half hour before dinner. Staff on the unit was counseled regarding the proper procedure when residents refuse to have their vital signs taken.	

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F 281	<p>Continued From Page 15</p> <p>25 mg tablet, however she stated she assumed that if it was less than 100 it would not have been given previously to her administration. Review of the resident's weekly blood pressure record revealed the last recorded blood pressure to be 102/60 on 2/11/09 and that the resident had refused to have his blood pressure taken on 2/18/09 and 2/25/09. The medication nurse confirmed that she was not aware that he did not have a current weekly blood pressure reading.</p> <p>2. On 3/3/09 at 9:17 a.m., the medication nurse was observed administering oral medications to Resident 32. The medication nurse gave a 20mg capsule of Omeprazole (Omeprazole is in a class of drugs called proton pump inhibitors (PPI) that block the production of acid by the stomach) and two 5mg tablets of Prochlorperazine (Prochlorperazine is used to treat psychotic disorders such as schizophrenia; it is also used to treat anxiety, and to control severe nausea and vomiting.)</p> <p>Review of the physician's medication recap report for Resident 32 revealed Omeprazole 20mg was ordered to be given twice a day before meals (before breakfast and dinner), and prochlorperazine maleate two 5 mg tablets were ordered to be given each morning 45 minutes prior to breakfast.</p> <p>During an interview with the medication nurse on 03/03/09 at 11:45 a.m., the medication nurse confirmed that she did not know if the resident had eaten breakfast or when he was going to next eat a meal explaining that he gets up late and eats according to his particular desires. Review of the medication administration record documents that these medications ordered in relation to meals are given at standardized times. Review of the Policy titled " Medication Administration, Times" states that "before meals" medication administration times are not standardized and that administration should be</p>	F 281	<p>Continued from page 15:</p> <p>Finding 2. The nurse who changed the dressing during the observation by the surveyor received counseling and will receive remedial training in the area of wound care, measurement, and documentation on 3/25/09. She will not provide care until her skills meets the facility's policy guidelines.</p> <p>After the nurse receives training in wound care, the SRN on Unit 2E will observe 3 dressing changes provided by this nurse to ensure she follows the required techniques. Nurses will be periodically monitored during medication passes by the SRNs.</p> <p>The SRN will send an email to all nurses reminding them to review the old Medication Administration Record (MAR) against the new MAR to include all items that pertain to specific medications which includes bringing forward that last weekly blood pressure used to monitor a B/P medication. The email will include what to do if a resident refuses vital signs and that if a resident is non-compliant in following the right time to take medications, provide patient teaching, notify the physician and document.</p>		

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F 281	Continued From Page 16 as close to the actual event as is feasible unless a specific time is ordered by the physician. 2. On 3/2/09, observation of licensed Staff B, during a dressing change for Resident 14, revealed the physician's order was not followed. Review of the physician's order dated 2/20/08, indicated to "start treatment order to sacral/coccyx area as follows: Cleanse entire area with sterile Normal Saline" Prior to the dressing change, Staff B poured normal saline onto a 4 X 4 gauze pad in a souffle cup. In the residents bathroom, Staff B ran tap water into the souffle cup. Staff B picked up the gauze and patted the wound three times. Staff B did not cleanse the entire area by rinsing away debris or cleaning products left from the bedbath with sterile normal saline. During an interview immediately following the dressing change, Staff B stated she was unsure how to implement the physician's instructions to cleanse the entire area with sterile normal saline. Staff B stated during the dressing change that the CNA had just completed peri/incontinent care, but did not know what products had been used on the affected area (the dressing was gone during the observation). On 3/3/09, review of the facility policy titled "Wound Treatment" instructed staff "to clean the wound and entire area with sterile water or saline solution as ordered. Leave the wound surface moist. Dry only the area around the wound."	F 281	Continued from page 16: The SRNs will make observations on nurses providing wound care on their units to ensure that wound care is provided as ordered. Nurses will be in-serviced through nursing education on the facility policy "Wound Treatment" to ensure that after cleaning a wound with sterile water of saline solution as ordered, the wound surface is to be left moist, and the nurse is to dry only the areas around the wound. Responsible: Supervising Registered Nurse Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.	04/23/09
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F 323 Plan of Correction: The facility will ensure resident environments remain as free as possible of accident hazards and residents receive adequate supervision and assistive devices to prevent accidents.	

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F 323	<p>Continued From Page 17</p> <p>prevent accidents.</p> <p>This Requirement is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to ensure the resident dining room on 2E was free of accident hazards due to a leaking ice machine. The facility also failed to ensure 1 of 30 sampled residents (Resident 22), received adequate assistance during a transfer and assistance devices to decrease his potential for falls.</p> <p>Findings:</p> <p>1. On 3/2/08 at 12:30 p.m., in the residents' dining room on 2E, a plastic round tub with approximately 2 inches of water was observed on the floor slightly under the corner of the dripping ice machine. The residents' dining table was situated approximately two feet from the tub of water. In a random interview at 1:05 p.m., a CNA stated the ice machine was leaking for some time and occasionally a resident would walk or wheel into the water tub. A request for the facility work order revealed a work request dated 9/28/2007. Staff D stated in an interview on 3/4/09 at 4 p.m. that the ice machine needed to be replaced and was on back order.</p> <p>2. On 3/2/09 at 9:30 a.m., Resident 22 was requesting assistance to get out of bed. Staff C was observed assisting his transfer from the bed to the wheelchair, without lowering the bed completely. Staff C was assisting the transfer by herself.</p> <p>On 3/3/08 at 3:00 p.m., Resident 22 was observed in his bed with a disconnected string alarm on his bed. The string goes from the foot of the bed to the side rail and is attached to a</p>	F 323	<p>Continued from page 17:</p> <p>Finding 1: A Track-it Work Order was submitted to Plant Operations on 3/23/09. (Plant Operations was contacted by telephone the day of survey). A new ice machine has been on order since 9/28/08. Plant Operations recently worked on the machine and it is not currently leaking Responsible: Supervising Registered Nurse Monitor: The SRN will monitor the ice machine on a weekly basis and report any problems to Plant Operations.</p> <p>Finding 2. The string alarm for Resident 22 was discontinued as it was no longer effective. The care plan was revised to reflect this change. The resident's need for a two-person assist will be added to the CNA's Information Sheet, so that anyone working with Resident 22 is aware of this need. Physical Therapy will be requested to review Resident 22's transfers to determine if a 2-person assist is required.</p> <p>Ward 2D nursing staff will receive an in-service on Resident 22 to ensure they are aware of his need for a two-person assist and to remind them to make sure these special needs of Resident 22 are added to the CNA's Information Sheet so that all staff who care for the resident are aware.</p>		04/23/09

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F 323	Continued From Page 18 small box that alarms when the resident attempts to slide out of bed below the side rail and pulls the string from the box. During interview at 3:05 p.m. the licensed nurse stated that the resident takes off the string alarm and they keep taping it back on. The resident nodded in agreement. Review of the plan of care on 3/4/09 at 3:30 p.m. indicated that on 9/12/08 the interdisciplinary team agreed to add the string alarm, "Add string self-releasing alarm when resident attempts to get up at bedside." Additionally there was no physician's order for the string alarm. The plan of care also instructed that the resident requires a two person transfer.	F 323	Continued from page 18: Nursing staff will receive house-wide in-services about what to do when an intervention such as a string alarm is ineffective and how to ensure that interventions in care plans are followed. Responsible: Supervising Registered Nurse Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.		04/23/09
332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This Requirement is not met as evidenced by: Based on two medication pass observations, record review, and staff interview, the facility failed to ensure that it was free of a medication error rate of five percent or greater. The facility failed to administer three medications without error for one non-sampled resident (Resident 32). Two different medication passes with two different nurses were observed and there were a total of 46 opportunities for error. The facility's medication error rate was 6.5 percent. Findings: On 3/3/09 at 9:17 a.m., one medication nurse was observed administering oral medications to an non-sampled resident (Resident 32). The	F 332	F 332 Plan of Correction: The facility will ensure that medications are administered in accordance with physician orders. The nurse who was observed on the Medication Pass on 1C received in-service on the facility's policy/procedures "Medication Administration Standards" and "Medication Administration Times." There was no adverse effect to the resident. For Resident 32, his Medication Administration Record was revised and now includes daily monitoring of B/P prior to giving Metoprolol Tartrate. The physician re-evaluated the resident's medication and decreased the dosage of Omeprazole and Prochlorperazine from twice a day to once a day, a half hour before dinner.		

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F 332	<p>Continued From Page 19</p> <p>medication nurse gave the resident one tablet of Metoprolol Tartrate 25mg (a blood pressure medication), and a 20mg capsule of Omeprazole (Omeprazole is in a class of drugs called proton pump inhibitors (PPI) that block the production of acid by the stomach), and two 5mg tablets of Prochlorperazine (Prochlorperazine is used to treat psychotic disorders such as schizophrenia; it is also used to treat anxiety, and to control severe nausea and vomiting.)</p> <p>Review of the physician's medication recap report for Resident 32 revealed an order for Metoprolol Tartrate 25 mg tab to be given at 9:00 a.m. and 6:00 p.m. and to hold the medication if the resident's weekly systolic blood pressure was less than 100. Omeprazole 20mg was ordered to be given twice a day before meals (before breakfast and dinner) and Prochlorperazine Maleate two 5 mg tablets were ordered to be given each morning 45 minutes prior to breakfast.</p> <p>During an interview with the medication nurse on 03/03/09 at 11:45 a.m., the medication nurse confirmed she did not specifically know what the resident's weekly systolic blood pressure reading was prior to administering the blood pressure medication, Metoprolol Tartrate 25 mg, however she stated that she assumed that if it was less than 100 it would not have been given previous to her administration. Review of the resident's weekly blood pressure record revealed the last recorded blood pressure to be 102/60 on 2/11/09 and that the resident had refused to have his blood pressure taken on 2/18/09 and 2/25/09. The medication nurse confirmed that she was not aware that he did not have a current blood pressure reading. When interviewed regarding the timing of the medications to be given before breakfast, the medication nurse confirmed that</p>	F 332	<p>Continued from page 19: Staff on the unit was counseled regarding the proper procedure when residents refuse to have their vital signs taken.</p> <p>Nurses will be periodically monitored during medication passes by the SRNs.</p> <p>The SRN will send an email to all nurses reminding them to review old Medication Administration Records (MAR) against the new MAR to include all items that pertain to specific medications which includes bringing forward that last weekly blood pressure used to monitor a B/P medication. The email will include what to do if a resident refuses vital signs and that if a resident is non-compliant in following the right time to take medications, provide patient teaching, notify the physician and document.</p> <p>Responsible: Supervising Registered Nurse</p> <p>Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p>	04/23/09

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F 332	Continued From Page 20 she did not know if the resident had eaten breakfast or when he was going to next eat a meal. The nurse explained that the resident gets up late and eats according to his particular desires. Review of the medication administration record documents that these medications ordered in relation to meals are given at standardized times. Review of the Policy titled "Medication Administration, Times" states that "before meals" medication administration times are not standardized and that administration should be as close to the actual event as is feasible unless a specific time is ordered by the physician.	F 332	Continued from page 20:	
F 356 SS=D	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356	F 356 Plan of Correction: The facility will ensure nurse staffing data is posted on occupied units in a prominent place readily accessible to residents and visitors. Findings 1- 4. The required information for staffing data will be posted in the lobby of the Holderman Building, Annex 1, 2 and 3 (1D is now closed). An office staff member will collect the information and give the report to the SRNs in the morning for the Annexes and they will post the information in a prominent place that is readily accessible to residents and visitors. All SRNs will be instructed about the need to post the information on Annex 1, 2 and 3 by the supervising SNII by April 8, 2009. The SRNs who either supervise the annexes or cover for the SRNs when they are on vacation will monitor that the staffing data is posted as required.	

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F 356	<p>Continued From Page 21</p> <p>make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This Requirement is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to post required nurse staffing data on all units. The facility failure to do so created the potential for inability of the residents and the public to view the actual hours worked by nursing staff directly responsible for resident care per shift.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 3/3/09 at 10 a.m., observation of the required posted nurse staffing indicated the levels and numbers of staff that were scheduled for 24 hours. During concurrent interview, licensed Staff K stated that the posting included all of the staff scheduled for the skilled nursing units. 2. On 3/3/09 at 10 a.m. and 10:30 a.m., required nursing staff was not posted for resident and public view on the Eisenhower and Roosevelt facilities. 3. On 3/4/09 at 10 a.m. during the tour on Wards 7, 8, and 9, there was no daily nurse staffing data posted. During an interview on 3/4/09 at 10 a.m., licensed Staff H stated that staffing has never been posted publicly. 4. On 3/4/09 at 3:00 p.m. during a tour of 	F 356	<p>Continued from page 21: Responsible: Supervising Registered Nurse Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p>	04/23/09	

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F 356	Continued From Page 22 residences 1B, 1C and 1D, there was no nurse staffing data posted. During a concurrent interview with licensed Staff J, it was confirmed that staffing data is not publicly posted and that resident and visitors must request this information from the nursing station.	F 356	Continued from page 22:	
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: Based on observation, staff interview and review of the facility policy the facility failed to ensure sanitary conditions in the Holderman Building kitchen when cleaning items were in proximity to uncovered food. The facility failure to do so created the potential for the outbreak of foodborne illness. Findings: On 3/2/09 at 11:30 a.m., during a tour of the facility kitchen, in the walk in refrigerator there was a mop in a liquid filled bucket and brooms next to a wall. Within 3 feet were food carts with container trays of food about to be served. The doors of these carts were open. Hot foods were covered and cold foods, such as fruit and cottage cheese were uncovered.	F 371	F 371 Plan of Correction: The facility will store, prepare, distribute and serve food under sanitary conditions. The Food Service Technicians and Stock Clerks will ensure sanitary conditions are followed according to department policy and procedures. Uncovered food items will not be stored in close proximity to chemicals when cleaning the Central Retherm walk-in refrigerator. Floors in the re-therm refrigerator area will be cleaned when carts are not in the meal re-thermalization cycle. The policy/procedure for "Cleaning Hospital Kitchen Central Re-therm Refrigerator Floor" revised March 2009, will be reviewed with staff at an in-service and training documented. All Stock Clerks and Holderman Hospital Kitchen Food Service Technicians 1/11 will be trained by April 4, and on an as needed basis (new employees).	

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F 371	Continued From Page 23 During an interview the Food Service Supervisor stated that the doors to the carts were open because of the need for air circulation during the re-thermalization cycle. The supervisor added that this was the only time staff were able to clean the area. During an interview 3/3/09 at 12:15 p.m. the supervisor stated that the assigned person who does the cleaning is only here during this time. On 3/4/09 review of the facility policy regarding cleaning in the kitchen, revised March 2009, indicated that floors in this area are to be cleaned when carts are not in the meal re-thermalization cycle.	F 371	Continued from page 23: Any staff not properly following cleaning procedures will be counseled and will be reflective on individual performance records. Responsible: Food Service Supervisor I/II Monitor: The Food Service Supervisor I/II will monitor staff's weekly cleaning procedures of the walk-in refrigerator floor at scheduled times when carts are not in the re-therm cycle and proper protocol followed. Any staff not properly following cleaning procedures will be counseled and will be reflective on individual performance records.	04/04/09
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F 431 Plan of Correction: The facility will ensure drugs will not be kept in stock after their expiration date. Finding 1. All expired medications were discarded at the time of the survey on 1North. A thorough inspection of the medication room has been completed. The expiration dates were checked on all stock medications to ensure they had not expired. Finding 2. All expired medication was discarded at time of survey on 2E. The medication room was thoroughly inspected. Stock medications in all medication rooms throughout the facility will be inspected to ensure medications have not expired.	

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F 431	<p>Continued From Page 24</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This Requirement is not met as evidenced by: Based on observation, the facility failed to ensure that drugs shall not be kept in stock after the expiration date.</p> <p>Findings:</p> <ol style="list-style-type: none"> During the 1 North medication storage inspection on 3/2/09, the following medication was found to be expired: <ul style="list-style-type: none"> a. One 30 ml. bottle of Clotrimazole 1% topical solution, expired 12/08. b. Also noted in the medication storage room were the following expired supplies: <ul style="list-style-type: none"> Six Parapacks (for stool testing), expired 1/09. One bottle of Iodoform packing gauze, 1inch, expired 2/09. Observation of the 2E medication storage room on 3/3/09 at 9:30 a.m., revealed an open Multi Dose Vial of Lidocaine HCL without a label indicating "date opened/discard after." <p>During interview at 9:35 a.m., a licensed nurse</p>	F 431	<p>Continued from page 24: Pharmacy and Nursing Services (on NOC shift) will conduct monthly inspections to identify expired medications.</p> <p>The SRNs will communicate with the NOC shift nurse to ensure that the medication rooms are inspected monthly for expired medications. Responsible: Supervising Registered Nurses Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p>	04/23/09

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F 431	Continued From Page 25 stated the Multi Dose Vial should have been dated when opened and stored no more than 30 days. Review of the facility policy "Labeling and Storage of Drugs" on 3/4/09 at 3:30 p.m., indicated that licensed staff are instructed to place a label on the vial and document the date of initial entry. The policy further indicated the vial expires 30 days after first use, or earlier if manufacturer indicates.	F 431	Continued from page 25:	
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This Requirement is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to implement their Infection Control guidelines by assuring one certified nursing aide (CNA) kept her nails short. Findings: During the initial tour on 3/2/09 at 9:00 a.m., observation revealed Staff C had extremely long fingernails.	F 441	F 441 Plan of Correction: The facility will ensure that the Infection Control Program is implemented to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. The SRN had a discussion with the employee regarding nail length and cleanliness 3/3/09. The Infection Control policy that addresses this issue was shared with the employee. The unit SRN and Infection Control SRN evaluated the employee's nails to make sure they were clean and did not break the gloves. Employee will shorten nails by 3/30. The SRN will monitor. The Infection Control SRN will include nail monitoring as part of her observational rounds in the patient care areas.	

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F 441	Continued From Page 26 Review of the facility document titled "Infection Control Guideline 2.6 - Hand Hygiene" revised 3/15/05, indicated staff are to keep their nails short and clean. During interview on 3/3/09 at 9 a.m., Staff K acknowledged that the policy indicated staff are to keep their nails short.	F 441	Continued from page 26: Nursing staff will be in-serviced on the issue of nail length as part of the Infection Control policy by Nursing Education. Responsible: Supervising Registered Nurse Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.	04/23/09
F 456	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain all essential electrical equipment in safe operating condition. Findings: On 3/2/09, at 10:45 a.m., during tour of Ward 5, Eisenhower Annex, the room where electric chair and scooter batteries are charged was observed. An electric exhaust fan was mounted in the window. A sign posted near the fan instructed to keep the fan on at all times. Subsequent investigation, including interview with facility Plant Operations staff revealed that the fan was inoperable.	F 456	F 456 Plan of Correction: The facility will maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Plant Operations was notified of the broken fan in Eisenhower, Annex II, Ward 5 on 3/2/09. The electric exhaust fan mounted in the window of the electric wheelchair and scooter charging room was replaced by Plant Operations and operational on March 3. On 4/1/09 the SRN notified nursing staff on Ward 5 that they are to report any malfunctioning equipment to the SRN so that she can send a Track-It form to Plant Operations to have the equipment repaired. The SRN will monitor all rooms used by residents through the Environmental Rounds on a monthly basis to ensure that all equipment is functioning properly. Responsible: Supervising Registered Nurse/Plant Operations Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action. In addition, Plant Operations staff will check the room periodically when working in the area.	04/09/09
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2009
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NAME OF PROVIDER OR SUPPLIER N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599
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F 514	<p>Continued From Page 27</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This Requirement is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that clinical records on each resident be maintained in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 30 sampled residents (Residents 6, 19, and 11).</p> <p>For Resident 6, the fluid balance records were not consistently documented, calculated and /or verified, which created the potential for fluid and electrolyte imbalance.</p> <p>For Resident 19, the Fall Risk Assessment tool was not accurately assessed.</p> <p>The facility failed to timely document a transfer and reason for a transfer for Resident 11.</p> <p>Findings:</p> <p>1. Resident 6 has a percutaneous endoscopic gastrostomy (PEG) tube in place and currently receives Jevity 1.5, 1 can bolus, after the dinner meal.</p> <p>A dietary evaluation, dated 2/05/09, indicated the reason for the assessment was for weight loss and to followup on po (oral) intake. Notes indicate that Resident 6 had experienced a 5# significant weight loss within this last month.</p>	F 514	<p>Continued from page 27:</p> <p>F 514 Plan of Correction: The facility will ensure that clinical records are maintained in accordance with accepted professional standards and practices.</p> <p>Finding 1. Inconsistent documentation on the Intake and Output (I&O) has been identified as a concern and interventions have been discussed between the SRNs, SNIs and the Director of Nursing. All residents on I&Os will be assessed by the unit SRNs to determine if they require I&Os and if they do need their I&Os monitored, their care plan needs to include fluid intake requirements.</p> <p>Changes will be made regarding the I&O policy and nurses will be in-serviced to these changes through nursing education.</p> <p>Nursing staff will be in-serviced on the requirement to complete these forms and the requirement that the NOC shift nurse review this form nightly to ensure it is complete. If it is not, the NOC nurse will document on the Charting Omission Form and give that to the unit's SRN and a copy to the SNI for follow-up.</p> <p>Responsible: Supervising Registered Nurse</p> <p>Monitor: A monitoring tool for all residents on I&Os will be developed through the Nursing QA process. The unit SRNs will complete the tool monthly and report the results through the Long Term Care Quality Improvement Committee when it meets monthly.</p> <p>Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p>	04/23/09

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NAME OF PROVIDER OR SUPPLIER N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599
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F 514	<p>Continued From Page 28</p> <p>Goals include: No further weight loss < 139# with gradual weight gain in conjunction with diuretic treatment and no signs and symptoms of dehydration.</p> <p>Review of the fluid balance records indicate that 24 hour totals were not consistently documented and there was no documentation related to enteral feeding intakes on 2/23/09, 2/24/09, 2/25/09, 2/27/09, and 2/28/09.</p> <p>2. Record review on 3/4/09 at 2 p.m., indicated that Resident 19 had a history of falls documented on 7/10/08 and 2/20/09. The Morse Fall Scale form (an assessment tool) initiated 4/23/08, indicated Item number 1 titled "History of Falling." The dates that fall information was recorded for Resident 19 were 4/23/08, 8/20/08, 12/3/08 and 2/20/09. There were no falls listed under any of these dates as indicated by recorded scores of zero. Facility staff stated that Resident 19's fall on 7/10/08 should have been noted under the 8/20/08 date and the 2/20/09 fall should have been noted under the 2/20/09 date. According to the instructions on the reverse side of the Morse Scale form, if the resident had a fall, then it should have been indicated by a score of 25 under the appropriate date column for Item 1. The Morse Fall Scale form indicated that a total score (for all factors) of 51 and above would indicate that a resident is at high risk for falls. Resident 19's recorded total scores remained below 50 due to the lack of correct entries under item 1. Resident 19's fall risk assessment was listed erroneously as "low risk."</p>	F 514	<p>Continued from page 28:</p> <p>Finding 2. The two nurses on Ward 5 that failed to complete the Morse Fall Score correctly will receive written instruction by the SRN or SNII of the expectation of filling out the Morse Fall Score correctly.</p> <p>The SRN for Ward 5 will check the current Morse Fall Scores in the medical record on her unit to ensure they are completed correctly. Nursing staff will receive an in-service on the correct way to fill out the Morse Fall Score form by Nursing Education.</p> <p>The SRNs will monitor the Morse Falls Scores to ensure they are correctly filled out. If any discrepancies are found they will provide written instruction to the nurse about the error that was made on the form. Responsible: Supervising Registered Nurse Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p> <p>Finding 3. On 1/23/09 a physician's order was written to transfer Resident #11 to a "SNF bed when available." This was followed by an order to "Keep on dementia unit waiting list." Based on a late entry made in the Interdisciplinary Progress Notes on 3/3/09 for 2/19/09, an Interdisciplinary Team Meeting (IDT) was held to discuss his level of care; however the documentation could not be located.</p>	04/23/09

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NAME OF PROVIDER OR SUPPLIER N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599
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F 514	Continued From Page 29 3. On 3/2/09 during the orientation tour staff stated that Resident 11 was transferred from 1B to 2B. On 3/3/09 review of the resident record failed to document the transfer, the reason for the transfer, or preparation of the resident for the transfer. Licensed Staff G on 2B was interviewed concerning the transfer and reviewed the record and was unable to locate documentation that addressed the transfer. An Interdisciplinary note dated 3/3/09, after the interview, indicated a "late entry" for 2/19/08 that reflected an IDT was held for level of care. The note further indicated the resident was determined to need skilled care and not the memory unit. The record did not address any information regarding when the transfer took place and resident orientation to the new unit.	F 514	<p>Continued from page 29:</p> <p>On 3/2/09 at 11:45, Interdisciplinary Progress Notes state the RN Supervisor on the SNF (2B) was made aware of the resident's transfer to the unit and "D/C instructions given to patient- well understood." This was followed by an entry written at 12:00 by Social Services that states the resident "is looking forward to having his room on 2B."</p> <p>On 3/2/09, at 2:20 p.m., an entry by the licensed nurse on the Interdisciplinary Progress Notes states the resident was admitted to 2B and oriented to the ward and his room. This was followed by a SNF/ICF Orientation Checklist signed and dated by the resident upon his admission to the unit. Since the resident's admission to the unit, he has adjusted well. There has been no behavior or wandering issues that would warrant a transfer to a more secured unit (dementia unit) at this time.</p> <p>The SRN will ensure that all IDT's will be placed in the resident's medical record after the team meets. Nursing Education will provide an in-service to nursing staff about the facility's policy/procedure "Transfer within the Facility" Nsg 20-050.</p> <p>The SRNs will ensure that all resident transfers within the facility are completed per facility policy/procedure. The SRNs will report to their SNIs if any resident is transferred to their unit where the policy has not been followed.</p> <p>Responsible: Supervising Registered Nurse</p> <p>Monitor: Any pattern of negative findings will be reported through our Long Term Care Quality Improvement Committee for corrective action.</p>	04/23/09

California Department of Public Health

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the annual RECERTIFICATION SURVEY. Representing the Department of Public Health: Adrian Long HFEN, Ann Fitzgerald HFEN, George Ely HFEN, Paula Reichmuth HFEN, Carol Devita HFEN, Candice Bergseth HFEN and Bernadette Brown HFEN. The census on entry to the facility was 351 residents. The survey sample included 30 sampled residents and 2 non-sampled residents.	A 000	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code, Section 1250, and Title 42, Code of Federal Regulations (CFR) 405.1907. This plan of correction constitutes our written credible allegation of compliance for the deficiencies noted. (<i>AK</i>) Initials	
A1017	T22 DIV5 CH3 ART5-72551(b)(5) External Disaster and Mass Casualty Program (b) The plan shall provide procedures in event of community and widespread disasters. The written plan shall include at least the following: (5) Prompt transfer of casualties when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care. Procedures for moving patients from damaged areas of the facility to undamaged areas. This Statute is not met as evidenced by: Based on document review and staff interview, the facility disaster preparedness plan does not describe procedures for moving patients from damaged areas of the facility to undamaged areas. Findings:	A1017	A 1017 Plan of Correction: The facility disaster preparedness plan will describe procedures for moving patients from damaged areas of the facility to undamaged areas in the event of a disaster. The VHC-Y Emergency Operations Plan (Disaster Preparedness Plan) will be amended to include: If the discharge or relocation of patients from damaged areas of the facility to undamaged areas is necessary, the Incident Commander or designee will contact Plant Operations, Transportation, to arrange for the use of the multi-passenger transport vehicles. The VHC-Y maintains a fleet of 2 patient transport vehicles, 14 buses and 2 handicapped-equipped vans to transport patients in addition to standard mobility devices.	

Licensing and Certification Division

STATE FORM 8809 P1SD11

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Patricia M. Llaguno* TITLE *Standards Compliance Coordinator* (X6) DATE *3/20/09*

If continuation sheet 1 of 4

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA010000372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2009
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A1017	Continued From page 1 On 3/4/09 at 10 a.m., the facility Emergency Operations Plan was reviewed. The plan does not describe how patients would be moved, if necessary, from damaged areas of the facility to undamaged areas. During interview on 3/5/09 at 11a.m., Staff I acknowledged that the plan does not contain this required information.	A1017	Continued from page 1: Patient loading areas and potential routes of emergency transport are outlined on aerial photos of the facility. Amendments to the VHC-Y Emergency Operations Plan will be reviewed through the Emergency Preparedness Committee and distributed to all services. Responsible: Health and Safety Officer	04/23/09
A1018	T22 DIV5 CH3 ART5-72551(b)(6) External Disaster and Mass Casualty Program (b) The plan shall provide procedures in event of community and widespread disasters. The written plan shall include at least the following: (6) Arrangements for provision of transportation of patients including emergency housing where indicated. Procedures for emergency transfers of patients who can be moved to other health facilities, including arrangements for safe and efficient transportation and transfer information. This Statute is not met as evidenced by: Based on document review and staff interview, the facility disaster response plan does not describe the transportation arrangements for patients who would be moved to other health care facilities in the event of a disaster. Findings: On 3/4/09 at 10 a.m., the facility Emergency Operations Plan was reviewed. The plan does not specify modes of transportation and how transportation vehicles will be obtained to transport patients to another health care facility, if needed, during a disaster. On 3/5/09 at 11 a.m., Staff I stated that there are vehicles available and plans for obtaining them, but acknowledged that this information is not in the Emergency Operations Plan.	A1018	A 1018 Plan of Correction: The facility disaster preparedness plan will describe transportation arrangements for patients who would need to be moved to other health care facilities in the event of a disaster. The VHC-Y Emergency Operations Plan will be amended to include: The Medical/Technical Specialist or designee (as outlined in our initial Incident Management Team Organizational Chart) will coordinate transportation of patients to other health care facilities. Requests for multi-passenger transportation will be made through Plant Operations, Transportation, utilizing the VHC-Y fleet of patient transport vehicles. The VHC-Y transportation fleet will be augmented by contacting the Napa County Medical/Health Operational Area Coordinator when necessary to coordinate with local vendors, Piners Napa Ambulance Service and Evans Airport Service.	

California Department of Public Health

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A1019	<p>T22 DIV5 CH3 ART5-72551(b)(7) External Disaster and Mass Casualty Program</p> <p>(b) The plan shall provide procedures in event of community and widespread disasters. The written plan shall include at least the following: (7) Procedures for emergency discharge of patients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and at least one follow-up inquiry within 24 hours to ascertain that patients are receiving required care.</p> <p>This Statute is not met as evidenced by: Based on document review and staff interview, the facility disaster preparedness plan did not describe procedures for the emergency discharge of patients who can be discharged without jeopardy into the community.</p> <p>Findings:</p> <p>On 3/4/09 at 10 a.m. the facility Emergency Operations Plan was reviewed. The plan did not indicate procedures for the emergency discharge of patients who can be discharged without jeopardy into the community. The plan did not reflect methods for identifying those patients, how they would be transported, how care would be provided, and how a follow-up inquiry would be done within 24 hours to determine their status. During interview on 3/5/09 at 11 a.m., Staff I stated that this requirement was met since they considered the term "community" to include services and physical structures located on the grounds of the facility. Staff I acknowledged that the Emergency Operations Plan did not indicate procedures for discharging patients into the communities located geographically near the</p>	A1019	<p>Continued from page 2: A Memorandum of Understanding, Medical Emergency Cooperative Agreement for Healthcare Organizations is established between the County of Napa and the VHC-Y to provide coordinated emergency medical services in disaster responses.</p> <p>Amendments to the VHC-Y Emergency Operations Plan will be reviewed through the Emergency Preparedness Committee and distributed to all services. Responsible: Health and Safety Officer</p> <p>A 1019 Plan of Correction: The facility disaster preparedness plan will describe procedures for the emergency discharge of patients who can be discharged without jeopardy into the community.</p> <p>The VHC-Y Emergency Operations Plan will be amended to include: The Medical Care Branch Director will collaborate with the Medical/Technical Specialist or designee to ensure patients are rapidly assessed and moved to definitive care locations.</p> <p>The VHC-Y first priority will be to transfer or discharge patients into the VHC-Y Community, as determined by circumstances, utilizing our fleet of patient transport vehicles provided through Plant Operations, Transportation.</p> <p>The Medical Branch Director will collaborate with the Medical/Technical Specialist to identify and prioritize those patients in need of emergency transfer or discharge.</p>	04/23/09

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A1019	Continued From page 3 facility.	A1019	<p>Continued from page 3: Transfers or discharges outside the VHC-Y Community will be coordinated with local community hospitals by the Medical/Technical Specialist or designee pursuant to the Memorandum of Understanding, Medical Emergency Cooperative Agreement for Healthcare Organizations between the County of Napa, VHC-Y and local healthcare facilities.</p> <p>Arrangements made with local healthcare emergency contacts include: Queen of the Valley Medical Center, St. Helena Hospital, Napa State Hospital, Kaiser Permanente Medical, and the Community Health Clinic Ole.</p> <p>The Medical Care Branch Director will coordinate patient care and disposition of patients to ensure patient transfer tracking is done.</p> <p>The Medical Care Branch Director will coordinate follow-up inquiries within 24 hours to ensure that patients are receiving required care.</p> <p>Amendments to the VHC-Y Emergency Operations Plan will be reviewed through the Emergency Preparedness Committee and distributed to all services. Responsible: Health and Safety Officer</p>	04/23/09